Are You Satisfied with Your Service? An Analysis of Patient Satisfaction in Kentucky's Medicaid Population

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Executive Summary

The purpose of this study is to see if there are differences in patient satisfaction between African Americans and non-African Americans on Kentucky Medicaid. In addition, the study will ask if there are differences in satisfaction between diabetic and non diabetic recipients. Using the answers from 1,301 respondents to the 2005 Kentucky Medicaid Adult Satisfaction Survey, explanatory variables including race, age, gender, total medical costs and a diabetic indicator are analyzed using probit regressions to see if there are any statistically significant correlations between these recipient characteristics and recipient satisfaction with physicians, specialists or their health plan. I find that African Americans have a negative correlation with physician satisfaction as compared to Caucasians. Other races are less likely to be satisfied in all categories of satisfaction as compared to Caucasians. Age has a positive correlation with health plan and physician satisfaction; being female is positively correlated with specialist satisfaction. Total Medicaid cost has a positive correlation with health plan satisfaction. Being diabetic has no statistically significant effect on any category of satisfaction.

Implications of this study deal with clinical outcomes of recipients who are chronically ill. Failing to monitor or effectively treat chronic illness can result in substantial morbidity and increase the nation's health care costs. Not having adequate insurance may result in the costs of care being absorbed by health care professionals, ultimately paid by taxpayers through higher taxes to finance public hospitals and public insurance programs. With this care, there is anxiety over the quality of care that is obtained in order to reduce costs of health care services.

Recommendations for improvement include cultural competence training for health care providers, creating an Office of Minority Health for the state of Kentucky, working to educate patients about their health, treatment and lifestyles; and working to shift Medicaid into emphasizing preventative care instead of treatment for chronic conditions.

Introduction

The purpose of this study is to examine the determinants of patient satisfaction in the Kentucky Medicaid population. The research question I address is "Do factors such as race, gender, age, health status and chronic conditions make a difference in the satisfaction of Kentucky's Medicaid recipients?" Data is obtained from the 2005 Kentucky Medicaid Adult Patient Satisfaction Survey and the Kentucky Medicaid administrative databases. Through the use of probit regression models, the hypotheses this study will address are:

1. African Americans give lower scores of satisfaction in the areas of physician, specialist and health plan satisfaction.
2. Other races (which were not defined by the administrator of the survey) give lower scores in the areas of physician, specialist and health plan satisfaction than African Americans or Caucasians.
3. Medicaid recipient who have a higher total medical cost for 2004 give lower scores on the questions of physician, specialist and health plan satisfaction.
4. Females give higher satisfaction scores in the areas of physician, specialist and health plan satisfaction than males.
5. Older patients are less satisfied with their physician, specialist or health plan than younger patients.
6. Diabetics have lower satisfaction scores in the areas of physician, specialist and health plan satisfaction than non-diabetics.

I find that being African Americans is negatively correlated with physician satisfaction when compared to that of other races and Caucasians. Other races have a

negative correlation between in all categories of satisfaction. Older patients have a negative correlation with their physicians when compared to that of younger patients. Females have a positive correlation with specialist satisfaction. Total Medicaid cost has a positive correlation with health plan satisfaction. Being diabetic has no significant effect on any category of satisfaction.

I chose this study to examine factors which may hinder patient satisfaction with the health care system. Through various readings, the central theme of lower socioeconomic status is the propensity to be dissatisfied with their health care. Often, those in lower SES classifications are minorities and have lower incomes. Medicaid is a way to examine determinants for satisfaction with health care because the recipients meet certain eligibility requirements, such as income. African Americans are more likely to be on Medicaid or other publicly funded insurance than Caucasians. Since Medicaid began, the program has sought to provide equal access to medical care for low income beneficiaries. To be on Medicaid, one must fall below the federal poverty level or be disabled. Also, when examining public insurance, there are significant amounts of literature concerning Medicare and very little on Medicaid. The years which Medicaid traditionally covers (18-64) are vital to long term health. During these years, chronic conditions often develop and if left untreated can seriously decrease quality of life. The hindrance of the quality of life means that the recipient is likely to interfere with functions such as working. Without gainful employment, increases the likelihood of not having private insurance. Not having adequate insurance may result in the costs of care being absorbed by health care professionals, shifted into private insurers with cost shifting and higher fees or

ultimately paid by taxpayers through higher taxes to finance public hospitals and public insurance programs. With low income care, there is anxiety over the quality of care that is obtained in order to reduce costs of health care services. There was a significant push from the states to require Medicaid patients to enroll in managed care systems during the 1990s. Currently, examples of such shifts have proven cost effective but significantly decreased patient satisfaction with their health care (Blumenthal 1996).

Literature Review

Health care disparities

Race and ethnicity in the United States are correlated with health status. In terms of morbidity, mortality and disability, African Americans have poorer health than Caucasian Americans (Gornick, 2000). In 1997, 46% of African American deaths of all causes were calculated to be in excess of the overall death rate of whites. More specifically, approximately 120,000 more deaths occurred within the African American community than in the Caucasian community. Among the 10 leading causes of death for persons over the age of 65, African Americans had twice the death rate for diabetes mellitus (Satcher, 2005). It has been shown that during the middle years (ages 21-64) chronic disease can occur prematurely in racial and ethnic minorities and preventative health services are often underutilized. These years are deemed medically critical as predictors of the health of elderly Americans and ultimately raise health care costs (LaVeist, 2000). The African American community is also compounded by being more likely to be covered by Medicaid, and twice as likely to be uninsured even when employed. Finally, African Americans are less likely than white Americans to have a usual source of healthcare (Copeland, 2005).

The concept of healthcare disparities was put in the national forefront in 1984 with the establishment of the Department of Health and Human Services Task Force for Black and Minority Health. In 1985, the landmark Report of the Secretary's Task Force on Black and Minority Health was released. This comprehensive study was among the first of its kind to compare health disparities among African American, Hispanics, Asian/Pacific Islanders and Native Americans to those of Caucasian (MMWR, 1986). It

was presented to provide recommendations for policy development for healthcare disparities in the United States. Factors that contribute to disparities include lack of access to health care; barriers to care; increased risk of disability and disease resulting from occupational exposure; biological, socioeconomic, ethnic and family factors; cultural values and education; social relationships between majority and minority population groups, autonomous institutions within the ethnic minority group populations and culturally insensitive health care systems (Copeland, 2005). Though the concept of disparities is not new phenomena, attention to this area has been more prevalent in the last 20 years. In 1996, the Department of Health and Human Services renewed efforts within the Office of Minority Health to eliminate racial and ethnic disparities as part of Healthy People 2010. This effort involved collaborations with local agencies to improve care for members of minority groups who have specific health conditions such as diabetes. To this end, 34 states have Offices of Minority Health to reduce healthcare disparities. Some of the findings are that ending racial disparities could save five times more lives than technological advances (Satcher, 2005); and African Americans have a much lower life expectancy and worse health outcomes than Caucasian Americans (Office of Minority Health, 2005).

There has been much published on the health of minorities in their childhood or adolescent years as well as in the elderly population. However, the years between ages 21-64 are often neglected in the study of disparities due to this normally being a time of health in most adults lives (LaVeist, 2000).

Medicaid

Medicaid is a federal and state entitlement program that pays for medical assistance for certain individuals and families with low incomes and resources. Since its inception, Medicaid's purpose is to allow equal access to health care for all low income beneficiaries (Flint 2006). Under the federal guidelines, each state establishes its own eligibility standards; determines the type, amount, duration and scope of services provided; sets the rate of payment for services rendered; and administers its own program. However, this program does not automatically cover all poor people. Coverage falls under the categories of those of categorically needy which are federally matched and categorically related groups which are not federally matched—includes disabled, aged and chronically diseased persons. The scope of services provided by Medicaid generally include inpatient hospital services, outpatient hospital services, prenatal care, vaccines for children, physician services, nursing facility services for persons aged 21 or older, family planning services and supplies (CDC, 2005).

Medicaid is the source of insurance for approximately 1 in 7 Americans and accounts for more than 15 percent of the Nation's healthcare costs. It is the major source of Federal funding to the states. For those who have lower incomes or significant disabilities, Medicaid is typically the only provider for healthcare. For those who rely on Medicaid, private insurance is usually unaffordable or unavailable. Adults and children in low-income families make up 73 percent of Medicaid enrollees but constitute only 25 percent of the spending (Rowland, 2000). Nationally, Medicaid constitutes more than $200 billion dollars of the Federal budget per year or roughly $750 dollars per resident (Klemm, 2000).

In Kentucky, Medicaid makes up over $4.5 billion of the total State budget for the fiscal year 2006 or approximately $1,100 per resident. Currently, there are over 668,000 Kentuckians enrolled in Medicaid programs.

Diabetes

A leading cause of morbidity and reduced quality of life is diabetes. Diabetes affects over 18.2 million people in the United States. There are approximately 1.3 million new cases diagnosed in adults over the age of 20 every year (NHQR, 2005). For the 12.3% of the United States who are African American, the statistics are more grim. The prevalence rate of diabetes is 2-3 times higher for African Americans than for those of Caucasians (Williams 2005). In the African American population, over 13% have the disease in contrast to the 8.5% of the total population that is diagnosed with diabetes.

This is illustrated by 11.7% of African American adults are diagnosed with diabetes vs. 4.8% of Non Hispanic white. African Americans are also more likely to have complications from diabetes, being hospitalized at a rate of 72.6 per 1000 diabetics vs. 49.1 per 1000 non Hispanic white population. African Americans are also 1.3 times more likely to have a lower extremity amputation than non-Hispanic whites. Finally, African American diabetics die at a rate of 49.5 per 100,000 (Office of Minority Health, 2005).

In Kentucky, over 260,000 adults have diabetes. It is the fifth leading cause of death by disease in all races and one of 8 adults has diabetes (Kentucky BRFSS, 2003). It was the fourth leading cause of death among African Americans in Kentucky.

.Methods

The Institutional Review Board for the Commonwealth of Kentucky reviewed this research proposal and determined it exempt from review by the full Institutional Review Board pursuant to 45 CFR 46.101(b)(4).

Data Source

In order to address whether or not factors such as race, gender, age and health status are correlated with patient satisfaction, I will analyze combined data from the 2005 Adult Medicaid Satisfaction Survey and the Kentucky Medicaid administrative database. The satisfaction survey is sent to a random sample of recipients in the Kentucky Medicaid program. Responses are voluntary. Scores pertaining to satisfaction are extracted from survey questions:

- Question 5: We want to know the rating of your personal doctor/nurse using 0-10 with 0 the worst and 10 best;
- Question 11: We want to know the rating of your specialist using 0-10 with 0 the worst and 10 best; and
- Question 58: Using any number from 0 to 10 where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan?

Information on age, gender, race, and total Medicaid charges for 2004 and diabetes status are extracted from the Kentucky administrative database.

My initial data sample consisted of 1,301 individuals. Those who answered, "Do not have a physician/specialist, have not seen physician/specialist in last 6 months or do

not have health plan" were eliminated, reducing the size to 1,092. The characteristics of the sample are summarized in the following table:

Table 1: Descriptive Statistics for Kentucky Medicaid Sample

Variables	**Percentage or average**
Satisfaction measures (dependent variables)	
% Satisfied with Physician	80%
% Satisfied with specialist	46%
% Satisfied with health plan	84%
Descriptive statistics (independent variables)	
African Americans	7%
Caucasian	83%
Other races	10%
Female	68%
Average age of respondent	54 years
Average Medicaid expense for 2004	$7,618
% Diabetic	23%

The majority of those responding considered themselves satisfied with their physician and health plan, but not their care by specialists. The percentage of other races is the sample is larger than the percentage of African Americans. The sample is 68% female and the average age is 54 years old. The average amount of Medicaid expenditures in the sample for 2004 is $7,618 and 23% have a diagnosis consistent with diabetes.

The survey questions 5, 11 and 58 were used to measure how satisfied the patient is with their physician, specialist and health plan. These questions are all answered in a Likert style (responses are 0-10; 0 is the worst and 10 is the highest). In order to simplify the analysis, these responses are reassigned scores of either 0 or 1. A score of 0 indicates that the response to the question is recorded as ≤ 5 (unsatisfactory). Similarly, 1 is used for scores ≥ 6 (satisfactory).

Analysis:

Given the data described above, I estimate the relationship between recipient demographics and recipient satisfaction using probit regression models. Separate models are estimated for physician, specialist and health plan satisfaction. Here I am assuming that each recipient has a latent (unobserved) satisfaction level, Si* and that I only observe whether they are satisfied or not:

$$\text{Satisfaction}_i = 1 \text{ if } S_i^* > 5$$

$$\text{And } 0 \text{ if } S_i^* \leq 5.$$

This implies that for each of the three satisfaction measures I will estimate the following model:

$$Si^* = B_0 + B_1 * \text{African American}_i + B_2 * \text{Female}_i + B_3 * \text{Age}_i + B_4 * \text{Total cost}; \\ + B_5 * \text{Diabetic} + E_t$$

Here E_t is the standard error term. The estimated regression coefficient will tell me whether or not there is a statistically significant correlation between each variable and recipient satisfaction.

Results

The results from the estimation of the three probit models of recipient satisfaction are presented in Table 2. For each model estimated coefficients, standard errors and marginal effects are reported. Each of the models will be discussed in turn. First the model for physician satisfaction suggests that, everything else being equal, African American Medicaid recipients in Kentucky are 22 percentage points less likely to be satisfied with their physician than are non African Americans. The correlation is statistically significant at the 1% level. Since the baseline probability for physician satisfaction is 80% in the sample (see Table 1), this represents a 28% (.22/.80) decrease in the baseline probability of being satisfied with one's physician. In addition, other-race recipients are 9 percentage points less likely to be satisfied with their physician than are non African Americans or Caucasians. The result is significant at the 5% level and suggests an 11% reduction in the baseline probability for physician satisfaction. The other explanatory variables in the physician satisfaction probit model are not statistically significant.

The model for specialist satisfaction illustrates that with all else being equal, Non-White Medicaid recipients in Kentucky are 12 percentage points less likely to be satisfied with their physician than are African Americans and Caucasians. The correlation is statistically significant at the 1% level. Since the baseline probability for specialist satisfaction is 46 %in the sample, this represents a 26 % (.12/.46) decrease in the baseline probability of being satisfied with their specialist. In addition, females are 11 percentage points more likely to be satisfied with their specialist than males. This result is significant at the 1% level and suggests a 24% (.11/.46) increase in the baseline

probability for the specialist satisfaction. The other explanatory variables in the specialist satisfaction probit model are not statistically significant.

The model for health plan satisfaction suggests that, with all else being equal, Non-White Medicaid recipients are 9 percentage points less likely to be satisfied with their health plan than are African Americans and Caucasians. This correlation is statistically significant at the 5% level. The baseline probability for health plan satisfaction is 84%. This represents an 11% decrease in the baseline probability of being satisfied with one's health plan. In addition, each year of age decreases the probability of being satisfied with the health plan by 0.1 percentage points. This result is significant at the 1% level. The other explanatory variables in the health plan satisfaction probit model are not statistically significant.

Table 2: probit regression model results

Variable	**Physician Satisfaction**	**Specialist satisfaction**	**Health Plan Satisfaction**
African American			
coefficient	-0.66***	-0.233	-0.160
s.e	0.153	0.153	.017
marginal effect	-22%	-9%	-4%
Other races			
coefficient	-0.298**	-0.315**	-0.320**
s.e	.143	0.134	0.146
marginal effect	-9%	-12%	-9%
Age			
coefficient	0.00947***	0.00183	0.00666***
s.e	0.026	0.00222	0.00259
marginal effect	0.00259	0.07%	.16%
Female			
coefficient	-0.0146	0.282***	-0.0127
s.e	0.0938	0.0831	0.0978
marginal effect	.4%	11%	-.3%
Cost			
coefficient	0.442	0.00893**	0.00378
s.e	0.00509	0.00402	0.00418
marginal effect	0.12%	.35%	0.091%
Diabetic			

coefficient	0.378	0.142	0.0509
s.e	0.113	0.0940	0.115
marginal effect	0.399	5.64%	12.1%
Constant			
coefficient	0.378**	-0.454***	0.658***
s.e	0.155	0.136	0.156

*** significant to the 1% level ** significant to the 5% level

Discussion

In a study designed to examine patient satisfaction with Kentucky Medicaid, some hypotheses were supported and others were not. The data analysis showed that African American satisfaction with physicians was indeed negative. This may be due to not having a primary provider, meaning that often physicians are reassigned to patients as health plans are altered or change with consequent enrollment. For other races patients the negative correlation was much more consistent in the categories of physician satisfaction, specialist satisfaction and health plan satisfaction. This indicates that under the current delivery system of Kentucky's Medicaid program may not be meeting the needs of the other races in the state relative to Caucasians. Kentucky, like the nation, is rapidly becoming more diverse. The influx of immigrants, particularly those of Hispanic or Asian origin, brings different languages to the health care delivery system. Language barriers are considered a serious hindrance to receiving health care. Also, Hispanic cultures are subdivided due to various areas of origin. Each group has a culture and

dialect that is different from the other countries. Currently, very little research has been conducted on various origins of Hispanics and health conditions.

Costs were shown to have a positive correlation with specialist satisfaction. This could have implications under cost sharing (i.e. co pays, co-insurance). According to the GAO 2004 Health Care Forum, those in low income and chronically ill populations are directly affected if cost sharing increases. Also, this population is loyal to certain providers and will pay more in order to stay with their provider of choice.

Being female had a positive correlation with specialist satisfaction. This is significant due to the large female population in the state. By seeing obstetrics/gynecologists for female health concerns, this may shade the satisfaction with specialists as opposed to seeing more varieties of specialists—orthopedics, neurology or psychology.

Diabetes was selected due to it being a chronic condition that affects a significant portion of Kentucky's population. It also affects African Americans disproportionately. With diabetes having no significance in the satisfaction of physicians, specialist or health plans can be interpreted one of two ways: it is not a factor in these areas for the population surveyed or it is not being addressed adequately. There is a sizable population within Kentucky that is undiagnosed and is not seeking treatment for diabetes. If the 109,000 of undiagnosed diabetics became aware of their condition and were on Medicaid, there could be a shift from insignificant to significant findings.

Age was significant in both physician satisfaction and health plan satisfaction. Both of these areas were positively correlated. This project had a range from 18-95 years of age. This could be due to regardless of the age of the recipient; health care is dictated by

the health plan (Medicaid). Ultimately, Medicaid deals with income levels and health levels but not so much with age.

Limitations

There are several limitations to this project. One would be the sample collected. This sample was collected from voluntary responses of those who are currently on Kentucky's Medicaid population. Out of the over 600,000 who are enrolled in the program only 1,301 responded. This has the potential to leave different racial/ethnic groups out of the calculations because they did not return the survey. It may also change the significance of the results in question. Access to this data is another limitation to this study.

Next Steps

To advance this project, this whole study could be replicated on another chronic condition. Those results could be used in comparison to the results gathered to see if there is a trend or if each case is isolated. It would also be noteworthy to compare the satisfaction of people on state issued insurance (i.e. Medicaid) vs. those in a large private insurance pool. This way it may be possible to see if the satisfaction measures are just visible in the public insurance sector or if it is a trend.

Financially, this project could undergo a financial analysis using the individual costs reported by the survey respondents. There could be a relational study to show if there is a limit to spending where satisfaction is affected (becomes negative or positive; becomes statistically significant). A utility function to determine what is the point where spending

another dollar of services no longer benefits satisfaction or health could also be beneficial in this project.

Implications and Policy Objectives

To examine health disparities within in the state, an Office of Minority Health (OME) should be established. By having an OME established, there would be an agency integrated with the State Government who can examine Medicaid and Medicare for disparities. Also, OME could look for trends in disparities and develop policies and recommendations to work towards eliminating them. Currently, there are 34 states with an Office of Minority Health. This would fall in line with House Bill 213 which was introduced in the 2006 legislative session to reduce health care disparities and improve quality of life of racial and ethnic groups in Kentucky.

Another bill of interest would be Senate Bill 364, which introduces cultural competency education of healthcare providers. Currently, only a small number of medical schools provide training in cultural competence nationwide. As the State becomes more diverse, it will be imperative to be familiar with customs/cultures of immigrants in order to understand the patient's value system. In the area of communicating with patients who may be of foreign origin, interpreters or use of multi-lingual practitioners could help close the gap.

By 2030, 40% of the United States population will consist of ethnic and racial minorities (Copeland, 2005). Understanding value systems and health interconnectedness will be vital to improve the health of the nation and minority populations. For example, in African American women diabetes, hypertension, coronary heart disease and cerebrovascular disease are risk factors for cancer. Currently, there is a focus on prevention and treatment of chronic disease. Instead a shift to wellness may work to delay or reduce the onset of chronic disease.

Education of the patient will continue to be vital to improving the quality of life and quality of care to minority populations. For example, there is a history of self-care in the African American community. These traditions were developed at a time when access to medical care was severely restricted and have been passed from generation to generation. These methods (castor oil, hot toddies—alcoholic beverages for severe colds and influenza) may be contraindicated for chronic illnesses. To be able to integrate healthy lifestyle choices with current information but being able to value the culture, may improve the care of the chronically ill as well as increase compliance to a health care regimen.

Medicaid will need to shift from treatment of chronic conditions (reactive) to prevention of chronic conditions (proactive). By placing emphasis on prevention, health outcomes of adults may improve. One way to do this is using collaborative process treatment plans. By using a collaborative process treatment plan, patients share in developing care plans and the frequency of visits with providers. This care plan is patient centered, which results in better treatment adherence, satisfaction and health outcomes (Ciechanowski, 2006).As health outcomes improve, a higher quality of life might be regained that could lead to steady employment and the opportunity to obtain private insurance. Again, not having adequate insurance may result in the costs of care being absorbed by health care professionals, shifted into private insurers with cost shifting and higher fees or ultimately paid by taxpayers through higher taxes to finance public hospitals and public insurance programs. However, there is anxiety over the quality of care that is obtained in order to reduce costs of health care services. Previously, there was a significant push from the states to require Medicaid patients to enroll in managed care

systems. Currently, examples of such shifts have proven cost effective but significantly decreased patient satisfaction with their health care (Blumenthal 1996). Other studies have shown that by not having health insurance, the patient may delay seeking care and not seeking necessary care for potentially serious symptoms. This will result in the patient remaining in poorer health. Having a lower health status can make it difficult to purchase health insurance due to availability for their condition and price.

As a society we care about the health of the poor so we provide them with public health coverage. Since Medicaid began, the program has sought to provide equal access to medical care for low income beneficiaries. We are also worried about the cost of providing this coverage. Medicaid currently accounts for over $200 billion of the Federal budget and $4.5 billion of Kentucky's budget. For Kentuckians, this equals $1,100 for each resident. The literature suggests that patients less satisfied with their health providers are less likely to seek health care when they are sick. This is strongly related to the sector of health care in which the patients were seen. Lower income respondents were shown in the literature to have higher levels of dissatisfaction with health care than those of middle income. I observed that in KY Medicaid minorities in some circumstances are less satisfied with their health providers than non- minorities. Therefore, this suggests that these minorities are not going to seek out the same level of care as non-minorities. This is problematic because we would like all of the poor to utilize the program. It is also problematic because these minorities may put off going to the doctor until they are really sick and this will drive up the cost of treating them.

Conclusion

Race and ethnicity do play a role in health care in the United States. This is evident from the literature with its multiple reports of how race, culture and ethnicity are all avenues for differential treatment both historically and in modern practice. This study has helped to show that race and ethnicity play a role in patient satisfaction in Kentucky's Medicaid system with having statistically significant negative correlations in both African American and other race sectors. For other races, there is a negative correlation in every category (physician, specialist and health plan) that is not seen in any other subgroup. Other factors that contribute to patient satisfaction in Kentucky's Medicaid are age and sex. Age has positive correlations in satisfaction with physicians and health plans. Females are 11% more likely to be satisfied with their specialist than the male Medicaid population.

By examining Medicaid it also aids with the examination of the "middle years." These are the years in which most chronic conditions develop and are the most treatable or curable. By trying to improve the health of all people during these vital years, it may be possible to get them back onto private insurance (via employment) or at worst, lessen serious complications in the later years increasing the burden on Medicare.

Implications of this study deal with clinical outcomes of recipients who are chronically ill. Failing to monitor or effectively treat chronic illness can result in substantial morbidity and increase the nation's health care costs. Not having adequate insurance may result in the costs of care being absorbed by health care professionals, ultimately paid by taxpayers through higher taxes to finance public hospitals and public

insurance programs. With the provision of this care, there is anxiety over the quality of care that is obtained in order to reduce costs of health care services.

The scope of this study was limited by time and resources, but it helps to show how determinants affect satisfaction in Medicaid. The next step would to see if there is an upper limit for spending per patient before satisfaction decreases. This would help to show the effectiveness of each Medicaid dollar being spent on the patient. If there was a point where the health benefits no longer outweighed the price, at this point there may be an indication of how much money is needed for the entire population. This would be used for budget projections and not to limit the monetary benefits to the population.

Relevant Courses

- HA 601—Overview to the U.S. Health Care System: This course serves as an introduction to the United States health care system. Topics include terminology and health insurance.
- HA 621—Quantitative Methods of Research: The purpose of this course is to develop research design skills, including the selection of appropriate tools for statistical analysis.
- HA 656—Health Program Evaluation: The purpose of this course is health program evaluation. It exposed the student to the process of constructing a survey and how to score and evaluate survey results.
- HA 673—Health Policy: This class discussed various issues that pertain to the United States health care system. Among items discussed include Medicaid/Medicare, the Medicare Modernization Act and state's responses to each of the governmental influences in health care.

Appendix: Frequently Used Terms

Other races—for this study, survey respondents who identified themselves as neither African American or Caucasian.

Medicaid—a federal and state entitlement program that pays for medical assistance for certain individuals and families with low incomes and resources.

Chronically ill/chronic condition--describe a group of health conditions that last a long time. Examples include diabetes, asthma, hypertension

Private insurance—insurance not provided by a federal or state government entity

Socioeconomic status (SES)-- based on family income, parental education level, parental occupation, and social status in the community

Health care disparities—unequal attainment of health care services between members of a population.

Morbidity—causes illness in population; measure of disease in the population

Mortality—causes death in the population; measure of death by causes in population

Diabetes—in this study, diabetes includes type I and type II

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